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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2011-962*

13 **JOSE ASUNCION DY**
14 **179 Picadilly Circle**
Vallejo, CA 94591
Registered Nurse License No. 418090

ACCUSATION

15 Respondent.

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17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
20 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
21 Consumer Affairs.

22 2. On or about August 31, 1987, the Board of Registered Nursing issued Registered
23 Nurse License Number 418090 to Jose Asuncion Dy ("Respondent"). The Registered Nurse
24 License was in full force and effect at all times relevant to the charges brought herein and expired
25 on June 30, 2010, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

DISCIPLINARY STATUTES AND REGULATIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

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7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

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"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

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1 decreased blood pressures and oxygen saturation levels. In addition during this time frame,
2 several cardiac measurements (cardiac output and cardiac index) were abnormal.

3 b. During the above time frame, Respondent did not notify Patient A's physician of his
4 progressively deteriorating condition.

5 c. Patient A coded at approximately 4:46 a.m., on July 14, 2007, and expired later that
6 evening.

7 SECOND CAUSE FOR DISCIPLINE

8 (Gross Negligence/Incompetence – In Regards to Care Delivered to Diabetic Patient)

9 14. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of
10 gross negligence and/or incompetence in that while employed as a registered nurse at Kaiser
11 Permanente in Vallejo, Respondent failed to follow Kaiser's protocol regarding the monitoring of
12 a patient on an insulin drip. The facts in support of this allegation are as follows:

13 a. On July 4, 2007, Respondent assumed care of Patient B, a diabetic who was on a
14 continuous infusion of insulin.

15 b. The Kaiser Permanente Doctor's Order Sheet for Continuous Intravenous Insulin
16 Infusion Orders stated that the patient's blood glucose should be checked every one hour while
17 the patient was on an insulin infusion or every two (2) hours if the blood glucose was within the
18 target range of 80 to 140 mg/dl for four (4) hours, and the insulin dose had not been changed.

19 c. Patient B's blood glucose level was checked by Respondent at 9:00 a.m., and noted to
20 be 76 (outside the target range). At this time, Respondent decreased the dose of the insulin that
21 was being infused. However, at 10:00 a.m., Respondent did not recheck Patient B's blood
22 glucose as required by the physician's order.

23 d. At 12:00 p.m., Respondent checked Patient B's blood glucose and noted that it was
24 152 (outside the target range). Respondent did not adjust the amount of insulin being infused as
25 required by the physician's order. At 1:00 p.m., Respondent did not recheck Patient B's blood
26 glucose as required by the physician's order.

27 e. At 2:00 p.m., Respondent checked Patient B's blood glucose and noted that it was
28 151 (outside the target range). Respondent did not adjust the amount of insulin being infused as

1 required by the physician's order. At 3:00 p.m., Respondent did not recheck Patient B's blood
2 glucose as required by the physician's order.

3 THIRD CAUSE FOR DISCIPLINE

4 (Gross Negligence/Incompetence – Mislabeling Blood Specimen)

5 15. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of
6 gross negligence and/or incompetence in that while employed as a registered nurse at Kaiser
7 Permanente in Vallejo, on July 4, 2007, Respondent drew blood from Patient C and labeled the
8 specimen with the name of another patient. Said conduct subjected Patient C to delayed care and
9 could have resulted in incorrect treatment based on the mislabeled blood specimen.

10 FOURTH CAUSE FOR DISCIPLINE

11 (Gross Negligence/Incompetence – Narcotic Discrepancy)

12 16. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of
13 gross negligence and/or incompetence as defined in Code section 2762(e) in that while employed
14 as a registered nurse at Kaiser Permanente in Vallejo, Respondent made inconsistent and/or
15 unintelligible entries in hospital records regarding the administration of Morphine Sulfate. The
16 facts in support of this cause for discipline are as follows:

17 a. On July 4, 2007, Respondent assumed care of Patient D, who had a physician's order
18 to receive 60 milligrams of Morphine Sulfate every six (6) hours. Accordingly, Patient D was
19 scheduled to receive the Morphine Sulfate at midnight, 6:00 a.m., noon and 6:00 p.m.

20 b. Respondent initialed on Patient D's Medication Administration Record that he
21 administered 60 milligram of Morphine Sulfate at noon on July 4, 2007. However, this
22 medication had not been withdrawn from the Pyxis. Instead, at 3:38 p.m., Respondent withdrew
23 60 milligrams of Morphine Sulfate for Patient D, with no documentation in the patient's chart or
24 hospital record that the medication was administered.

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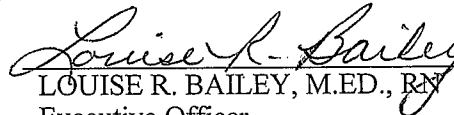
PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 418090, issued to Jose Asuncion Dy.
2. Ordering Jose Asuncion Dy to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3.
3. Taking such other and further action as deemed necessary and proper.

DATED: _____

6/3/2011


LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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